THE CONDUCT OF THE PSYCHOTHERAPEUTIC INTERVIEW

The Conduct of the Psychotherapeutic Interview

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The Conduct of the Psychotherapeutic Interview

Mandatory for psychotherapy is a thorough understanding of the process of interviewing. This is because communication is the channel that vitalizes the therapist-patient relationship. Its structured manipulation through interviewing is a studied attempt to influence the mental processes of the patient toward therapeutic gain.

The very act of verbalizing has certain releasing values for the person. It provides a kind of emotional catharsis in which the individual discharges quantities of pent-up tensions and feelings. The benefits of "talking things over" with a sympathetic person and of "getting off one's chest" burdensome thoughts and painful feelings are well known. Irrespective of any advice received, the mere ventilation of attitudes and emotions helps the individual to evaluate the situation better and to approach problems in a more constructive manner.

These beneficial effects, unfortunately, are short-lived. While the person may quiet down for a while and perhaps approach life with renewed vigor, any vexations provocative of tensions usually continue in force. When sufficient tension accumulates, one will find oneself in precisely the same position as before, requiring further cathartic release to appease unrest.

Instead of permitting a discursive rambling productive of emotional catharsis, the organized interview promotes a selective scrutiny of verbalizations. Focusing the patient's attention on certain aspects of personal experience and the deft choice of the therapist's comments facilitate an understanding of underlying feelings.

Each interview in therapy that emphasizes cognitive awareness of and insight into one's problems necessitates a number of activities on the part of the therapist. These are summarized in Table 19-1. An elaboration of these and other items will constitute the subject matter of this chapter. In supportive and reeducative therapy where there are more directive activities than in reconstructive therapy, interviewing to determine the status of the patient's thinking and feeling, and particularly resistance, are still of great importance.

Table 19-1
Activities of the Therapist

I. Opening the Interview

II. Maintaining the Flow of Verbalizations

- A. Managing pauses
- B. Managing silence

III. Directing the Flow of Verbalizations: The Principle of Selective Focusing

- A. Identifying an important theme
- B. Reading between the lines
- C. Guiding the theme into a goal-directed channel
- D. Guiding the theme into a goal-directed channel

IV. Inculcating Insight

- A. Accenting
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- E. Establishing connections
- F. Maintaining tension in the interview
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V. Terminating the Interview

THE RATIONALE OF INTERVIEWING

Ontogenetically, feelings antedate symbolic or verbal operations. Present at birth, they condition many of the automatic reactions of the child. With the development of the symbolic functions of the ego, feeling experiences become affiliated with verbal responses. The child then becomes better capable of identifying feelings. Coordinately, there develops an ability to exercise some voluntary control over emotions, as if the very linkage of thoughts with feelings encourages the capacity for such inhibition.

In neurosis a confusion in coding interferes with this acquired ability. The significance of many emotionally determined symptoms and behavioral patterns is baffling to most patients, the meanings having been subjected to repression. As a result, the patients are bewildered by their symptoms and compulsive behavior. They find it difficult or impossible to find words that lend meaning to their feelings or actions.

One of the aims of psychotherapy is to restore to patients control over their emotions. Before this can be done, they must be able to make the proper symbolic connections with their emotions. Therapeutic interviewing helps to accomplish this, and enables patients to scrutinize, identify, and elaborate on their feelings and the sources of those feelings. Patients then no longer feel helpless; they become capable of gaining some mastery over their emotions, which have hitherto operated autonomously.

This process was described by one patient in a note to the writer following a session during which she tried to verbalize her feelings of tension:

> As I talked, I just didn't know what was happening to me. I felt, at first, as if I was groping in mist, and then I started feeling better. I felt that I was not helpless, that there might be something behind the tension. When I left, I realized what some of my difficulties were, and that realization brings releases from a great many tensions. I noticed I had greater physical energy (still far from its peak), improved memory for small details of organization of work and of every-day living, and Saturday night I approached the vitality which I had three years ago. I must go further into my sympathies for the underdog and into my feelings that I am a second class citizen because I am a woman.

THE LANGUAGE OF THE INTERVIEW

Verbal Communications

A common language is essential for the conduct of the interview. Problems arise where the therapist and the patient do not understand or speak the same language.

Problems may also develop where there is a marked disparity in education, cultural background, and socioeconomic level or where the patient comes from an area of the country in which a local dialect contains unusual colloquialisms. Here the flexibility of the therapist will be put to test, for it is the therapist who will have to make the adjustment, not the patient. This will necessitate an inquiry, from time to time, into the meanings of the words and concepts used by the patient, with adoption of these in

the vocabulary of the therapist.

The use of vocabulary similar to that employed by the patient helps interviewing. Many patients lack the sophistication necessary for the understanding of complex psychologic ideas. It is essential to recast these into simple words and phrases that are readily comprehensible to patients. Even well-educated persons may not grasp the meaning of certain interpretations and comments of the therapist, although these apparently have been clearly stated. A definition of terms may be essential. Additionally, after the therapist has offered clarifications and interpretations, it may be necessary to check the patients' understanding by asking them to formulate what has been said, in their own words. In the event there is a lack of understanding, a reformulation may be made by the therapist, and another check then executed of the patient's comprehension.

The therapist should judiciously watch the personal need to impress the patient with complex words and high-sounding phrases. The use of language that is as unadorned and straightforward as possible will guarantee best results in interviewing.

Nonverbal Communications

Nonverbal communications during interviewing reveal aspects of the self that evade verbal expression. The patient is as much aware of the therapist's moods through the latter's nonverbal behavior as the therapist is of the patient's emotions. Thus, the patient often picks up attitudes of disinterest and annoyance expressed by the therapist through facial expressions, mannerisms, and behavior that belie verbal pronouncements of interest and concern.

Since individuals project themselves into every situation with their total personality, one may gain important clues to some of their underlying turmoil and their less conscious attitudes by observing their behavior in the therapeutic setting. Their gait, posture, facial expression, gestures, and mannerisms all reveal patterns, defenses, and facades that are either part of their habitual character structure or specifically reflect the role that they are playing with the therapist. One must make these observations casually so as not to give patients the impression that they are being watched like a specimen under a microscope.

It is usually easy to discern tension and anxiety in the patient by noting muscular spasms, which communicate themselves in gait peculiarities, fidgetiness while sitting in the chair, wringing of the hands, picking of the skin and lips, flushing, and lapses of attention conveyed by facial blankness. Anger is apparent in a stiffening of posture, clenching of the fists, tapping of the toes and grimness in facial expression. Enthusiasm and excitement are similarly evidenced by appropriate behavioral attitudes.

A check of one's own nonverbal manifestations may be necessary periodically to ascertain that one is not conveying disapproval, boredom, and irritation to the patient. Ideally, the therapist's facial expression should be pleasant, relaxed, and noncritical. Inappropriate scowling, frowning, and angry expressions are destructive to good therapy, as are continued acts of yawning, skin picking, wriggling in one's chair, and tapping of the extremities.

Head nodding is advantageously employed as a sign that the therapist is paying rapt attention and is following the associations of the patient. This is often accompanied by such vocalizations as “uh huh,” “mm hmm,” “yes,” and “I see.” Head shaking is used only occasionally as a sign of sympathetic understanding when the patient discusses personal suffering, or when the therapist wishes to communicate disapproval over what is going on. In the latter case it may be accompanied by a slight frown and the expostulations “mm mm”! or “hmm”! sharply expressed. A smiling facial expression is often employed to indicate acceptance and approval.

Subvocal utterances are also tremendously important during interviewing. How the patient says things may be as important as what he or she says. Inflections, intonations, accents, emphases, pauses, gaps in statements, slurring of speech, and varied sound expostulations may reveal to the therapist emotionally charged areas that the patient cannot put into words. By the same token, subvocal expressions and intonations influence the patient significantly. Frank (1961) cites a number of studies that illustrate this fact dramatically. For instance, during nondirective therapy it was possible to show that approbatory sounds and gestures at selected statements increased these categories from 1 percent in the second hour to 45 percent in the eighth hour. On the other hand, disapprobatory expressions reduced other categories from the 45 percent present in the second hour to 5 percent during the eighth hour. The therapist must, therefore, judiciously observe the *manner* in which remarks are presented to the patient to avoid an untoward effect. Voice training for therapists, where there are problems in

articulation, may be invaluable.

Silence may also be an important nonverbal tactic, applied when the patient is pondering or groping for solutions (Strean, 1969). It may also be employed as a way of stimulating tension to activate thinking and problem solving in the patient. It can, however, be overdone, and particularly in short-term therapy it should be used with discretion.

OPENING THE INTERVIEW

The First Interview

During the first interview it is highly desirable that the patient be put at ease and that the purpose of the interview be made clear. Consequently, the therapist is more active than at later interviews when the patient will have been subjected to more responsibility.

As the patient enters the therapist's office, the latter may greet the patient with a smile, gesture to the chair, invite the patient to be seated, and briefly introduce the general objectives of the interview. For instance, a man referred by his family physician for treatment walks through the door:

Therapist, (smiling) My name is Dr.__. Won't you sit down in that chair over there so that we can talk things over.

Patient. (*smiles, walks to chair, and seats himself)* Thank you, doctor. As you know, Dr. T. sent me here. He thought I needed psychiatric help. I've been going to him with a stomach condition for several years.

Th. Yes, he told me a little about your condition. I thought it might be helpful to talk things over in order to see whether you do need psychiatric help, and, if so, the kind of help that would be best for you. Would you like to tell me about your condition?

Pt. Yes, I have had this stomach trouble for some time. (*Patient continues to elaborate on his complaint factor.)*

The conduct of the first interview will be described in great detail in a later chapter, in which variations of approach will be considered, conditioned by special problems.

Subsequent Interviews

Later interviews are managed by briefly but pleasantly greeting the patient and waiting for an

opening remark. The reason for this is that one must avoid diverting from material that is disturbing or otherwise significant to the patient. In the event the therapist starts talking at the beginning, the patient may avoid discussing things that concern him or her most urgently. The patient may then either try to please the therapist by pursuing topics he or she imagines that the therapist wants to explore or the patient may welcome and take advantage of the opportunity to evade anxiety-provoking material. The therapist should avoid conventional pleasantries when greeting the patient and should refrain from the temptation to make "small talk."

Sometimes it is impossible for the therapist to avoid bringing up a reality problem at the beginning of the session. This naturally tends to divert the patient. In such a situation the therapist may attempt to retrieve the situation by saying, "Now, would you like to talk about yourself?" and then remain silent until a trend is defined.

Where the patient starts a session by sitting quietly without comment, he or she may merely be gathering fleeting thoughts. If silence continues, this may indicate resistance. In the former case the patient will soon start verbalizing; in the latter silence may be maintained. If, after a moment or so, the pause remains unbroken, the therapist may say pleasantly, "Well, what's on your mind?" An example of this illustrated in the following excerpt of an interview.

Because of an unavoidably prolonged telephone call, the therapist had to keep the patient waiting for several minutes. When the patient entered the room, he showed no sign of annoyance or anger. He sat in the chair, slowly removed a cigarette from a pack, lit it, and kept staring at the window. After a short interval he was interrupted.

Th. I wonder what's on your mind?

Pt. (pause) Oh, nothing. I just don't seem to have anything to say.

Th. Any reason for that?

Pt. I do …I don't know. I guess I was a little upset and irritated at having to wait.

Th. I'd be mad myself if I were kept waiting without reason. *[This comment is an attempt to support the patient, alleviate his guilt, and show him that he is not dealing with an arbitrary authority.]*

Pt. I suppose I'm too sensitive.

Th. After all, this time *is* yours. Whenever I do encroach on your time because of emergencies like this phone call, I try to make the time up by extending the session, or at a later one.

Pt. Thank you. (*smiling)* What I really wanted to talk about today was my reactions to being criticized. (*Patient continues exploring this trend.)*

In the event silence continues after the therapist's initial attempt to break it, the therapist may employ the techniques dealing with silence described in the following section of this chapter.

MAINTAINING THE FLOW OF VERBALIZATIONS

The encouragement of verbalizations is a prime task during interviewing. This is done by listening attentively to the patient, signaling that the therapist is following what is being said by nodding of the head, by controlled facial expressions, by such utterances, as "yes," "I see," and "mm hmm," and by carefully selected questions that indicate interest and understanding. As long as a patient continues on an important trend, fulfilling the specific goal toward which therapy is directed at the time, one does not interrupt. However, when there are too prolonged pauses, where the patient shifts concentration from the pertinent focus, or where one wishes to reflect feeling or to make interpretations, the therapist makes added verbal comments. There are some patients who need little encouragement apart from a few nonverbal interpolations. There are other patients with whom the therapist will have to manifest much more activity, perhaps even after every sentence.

Managing Pauses

Pauses in the verbal stream are to be expected and, in themselves, do not merit interruption. They are advantageously used by the patient to think through some ideas. When pauses continue for more than a moment or so, however, the therapist may do one of the following:

1. Repeat the last word or the last few words that the patient has used, with the same intonation as that of the patient, with a rising inflection, or with rephrasing as a question. The following part of an interview illustrates these:

Pt. I would say that there is a certain amount of tranquility now, but a lack of direction. A lack in the sense of what I expect. *(pause)*

Th. Expect? *[repetition of the last word] Pt.* Yes, what I expect out of life. I did use to enjoy some of the activities I

indulged in— drawing, painting, music—but I think those activities were enjoyed for their effect on other people.

Th. I see. *(nodding) [encouraging the patient to continued]*

Pt. I'm not interested in impressing people any more. Before this, if we went out, we saw people, and I was very particular about the way I dressed and shaved. Every little thing had to be just right. But now I don't care.

Th. Mm hmm. *(nodding) [encouraging his expression]*

Pt. I can come home late and rush and shave quickly. I don't particularly care how I look as much as before. Things are looking up. What I did before, something seemed to be lacking. *(pause)*

Th. Something seemed to be lacking, *[repetition of the last few words]*

Pt. I feel somehow that there was lack of pleasure. I'm not clear about it, but it has to do with sexuality, *(pause)*

2. Rephrase what the patient has said, either as a plain statement of fact or as a question. Continuing with the above interview:

Th. What do you mean that this lack has something to do with sexuality?

Pt. I feel that if such a thing is psychologically possible, that I was getting substitute satisfaction for sexuality. Careful how I looked, if there were attractive women around. By showing people how smart I was, or how cultured I was, or how rounded I was would show me as a great person, as though to cover up various lacks that I had, one of which was sexuality, my sexual performance, sexual craving, and that sort of thing. Now that I can find sexual pleasures, it's different, *(pause)*

Th. Now that you can find sexual pleasures all the substitute pleasure outlets have lost their driving force, *(pause)* *[rephrasing what the patient has said]*

Pt. That's exactly it. I would put all my energies into these things, and now that I can find sexual pleasure, I don't have to keep going in those other directions to find pleasure. But I miss it. *(pause)*

3. Ask a question related to the material under discussion to stimulate associations. Continuing the above interview:

Th. You miss something that still has value for you. I wonder if there were any other benefits you got out of some of the things you did? *[asking a question related to material under discussion]*

Pt. I miss the feeling that I'm not doing something constructive, something that adds to my stature.

Th. Mm hmm.

Pt. I would like to develop myself in as many directions as I can, feasibly. I don't know if it's completely neurotic. If it's partially neurotic, life to be lived and enjoyed for the moment it affords is not enough for me. As though I have to be building toward something, building something up, building myself up, growing, increasing in stature and

accomplishment.

Managing Silence

The significance of silence, when it occurs, must be appraised. Is it a defense? Is it an attack? Is it a pause in which creative cogitation is being executed? A common response to interpretation is silence, which may indicate that the interpretation is correct and startles the patient while he or she attempts to integrate it, or is incorrect, the patient responding with varied resistances or attempting to test its validity. Silence may reflect a fear of revealing oneself or of releasing anxiety as one approaches repressed conflictual foci. It may be a self defeating masochistic maneuver or a hostile act against the therapist.

If silence is perceived as a hindrance to the interview, it is dealt with in the same way as any other resistance. If it appears to be a transient phenomenon, it may be purposefully ignored. It is then handled by confrontation, by countersilence or other tactics. Fortunately, long periods of silence are rare in good therapy. Should it continue, the therapist may try the following in order.

1. Say “mm hmm” or “I see” and then wait for a moment.

2. Repeat and emphasize the last word or the last few words that the patient said.

3. Repeat and emphasize the entire last sentence or recast it as a question.

4. If this is unsuccessful, summarize or rephrase the last thoughts of the patient.

5. Say, “and” or “but” with a questioning emphasis as if something else is to follow.

6. If the patient still remains silent, the therapist may say, “You find it difficult to talk” or “It’s hard to talk.” This focuses the patient’s attention on his or her block.

7. In the event of no reply, the following remark may be made: “I wonder why you are silent?”

8. This may be succeeded by, “There are reasons why you are silent.”

9. Thereafter the therapist may remark, “Perhaps you do not know what to say?”

10. Then, “Maybe you’re trying to figure out what to say next?”

11. This may be followed by, “Perhaps you are upset?”

12. If still no response is forthcoming, a direct attack on the resistance may be made with, “Perhaps you are afraid to say what is on your mind?”

13. The next comment might be, “Perhaps you are afraid of my reaction, if you say what is on your mind?”

14. Finally, if silence continues, the therapist may remark, “I wonder if you are thinking about me?”

15. In the extremely rare instances where the patient continues to remain mute, the therapist should respect the patient’s silence and sit it out with him. Under no circumstances should one evidence anger with the patient by scolding or rejecting him.

A patient who had been manifesting greater and greater difficulty in talking finally became completely silent. The therapist tried to break the silence by employing some of the tactics just noted:

Th. I see … (*silence*) … when he went away? *[repeating last few words]* (*silence*) … You were talking about how little you miss your husband when he is away. [*repeating last sentence]* (*Patient remains silent).* Perhaps you don’t know what to say? (*silence)* Maybe you’re trying to figure out what to say next. (*silence*) Perhaps you’re upset. (*silence)* You find it difficult to talk. (*Patient is still silent.)* I wonder why you are silent? (*more silence)* There are reasons why you are silent. (*Silence continues.)* Perhaps you are afraid to say what is on your mind? *(no interruption of silence)* I wonder if you are thinking about me?

Pt. I know this is … sounds silly. But you *are* on my mind. I mean I keep thinking about you, sex, and all. Isn’t that terrible?

Th. You feel ashamed of some of the things you think about me?

Pt. (obviously agitated) Yes, it is so frustrating and it makes me mad. I imagine how you would be as a husband or a lover. I know one is supposed to react to their doctor, but this is so difficult. I’ve never really felt this way about any man.

DIRECTING THE FLOW OF VERBALIZATIONS

In formal psychoanalysis the verbal stream is undirected. The patient is enjoined to say whatever comes to mind without concentrating on any specific topic. Complete spontaneity is the keynote, and the absolute license in verbalization enables the patient to evade repressive barriers and to liberate derivatives of the unconscious, not ordinarily available to awareness. This process of *free association* is helpful toward mobilization of the transference neurosis, which becomes the fount of insight into the

most significant unconscious conflicts.

Free association is not employed in supportive and reeducative therapies. This is because one is not too much concerned with the content of the unconscious in these treatment methods. Free association may be used in non-Freudian analysis but rarely in analytically oriented psychotherapy because of the infrequent weekly visits and because the setting up of a transference neurosis is not ordinarily an objective in treatment. When free association is employed in the latter therapies, it often is used by the patient as resistance, for instance, as a means of diverting attention, of concealing the content of disturbing everyday problems, of seducing the therapist with words, of flaying oneself masochistically with recriminations, or of parading personal virtues in a narcissistic recital. If left to his or her own devices, the patient will frequently ramble along in verbalizations, veering away from anxiety-provoking material when crucial subjects are touched on. To allow the patient to follow such a circuitous thought channel may result in endless circumstantially, which serves as a defense against important verbalizations.

Instead of free association, the kinds of communication generally used in psychotherapy center around the focused interview.

THE PRINCIPLE OF SELECTIVE FOCUSING

In general, the process of selective focusing consists of initially identifying an important theme in the patient's verbalizations, of guiding this theme into a goal-directed channel, and of circumscribing the area of subject coverage.

Identifying an Important Theme

If one has followed the suggestions outlined in opening the interview—namely, not interfering with the thought content of the patient—the therapist will become aware of certain immediate preoccupations. Irrespective of how unimportant the therapist considers these to be, it is urgent to heed them carefully. They may be far removed from the material that the therapist wants to discuss, but to neglect or circumvent them, or to substitute other topics, constitutes a fatal error in interviewing.

Studies of the learning process show that the most effective learning occurs when the individual is concerned with things of strong emotional significance. Discussing material of no immediate interest to the patient interferes with learning; dealing with important moods and attitudes facilitates learning. This is why the therapist must be sensitized to current emotions and trends and not throw the patient off by introducing irrelevant topics or asking unrelated questions.

Sometimes it is difficult to select a dominant theme from the content of what the patient says. One may have to reach for feelings that lie behind verbalizations. Sometimes a great number of trends coexist, and the therapist may have trouble selecting one as more significant than the others. Focusing on certain themes by asking pointed questions may be helpful here.

For instance, a male patient talks about how hard things are for him because of the high cost of living. He is unable to afford luxuries any more. He needs new clothes; his wife wants a Florida vacation; his children are insistent on a new television set. Demands are being made on him to contribute a sum to a necessary charitable cause with which he is identified. He senses pressure from all sides, and this makes him feel disheartened and depressed. As he talks, the patient elaborates on each of the above items, justifying the reasonableness of the demands made on him.

It may be hard at first to discern what it is that preoccupies the patient most. Is it that he is complaining about the unjust demands made by his family or by the world? Is he expressing a hidden wish to receive rather than to give? Does he consider his inability to supply luxuries a sign of his failure to live up to responsibilities or to an idealized image of himself? Is he criticizing the therapist subtly for depleting his funds? Is he projecting dissatisfactions from some other source onto immediate tangible foci?

Indicated in these questions are a number of themes that we might pursue, some of which would be productive and others not. One might easily go off on a tangent by focusing on the virtues of new clothes, vacations, or television sets or by talking about the high cost of living. Expressing anger toward his family would be presumptive on the part of the therapist and perhaps too reassuring. Interpreting a hidden wish to receive on the basis of the material presented would be making a judgment without adequate evidence. At least some pre-conscious awareness by the patient of this wish would be necessary. There is,

similarly, insufficient evidence to warrant the interpretation that the patient is subtly criticizing the therapist for exploiting him. Focusing on his feeling that he is a failure in not being able to supply luxuries or make charitable contributions, however, may be one way of starting a more intensive inquiry into his feelings. The comment, "Do you think that there is something wrong with you for not being able to do these things?" may then be expedient.

On the other hand, the therapist may not desire yet to explore the area of the patient's self-depreciation and may want to obtain more associations from the patient before focusing. Accordingly, the therapist might remark, "You seem to be dissatisfied with things as they are." The latter statement may center the patient's attentions around his most provocative problems. This was the remark actually utilized during the session with the patient. A recorded fragment of the interview follows:

Th. You seem to be dissatisfied with things as they are.

Pt. Yes, I am. *(pause)* I sometimes wonder if I would do what I did if I lived my life through again. You see I really didn't want to quit school so early. But I had to get married. Sometimes I think it's a mistake to marry so young. You really don't have any idea about things.

Th. Do you feel *you* made a mistake in getting married so early?

Pt. Well, I do, in ways I really do. I could have waited, but she, my wife, insisted that we go ahead. And you know, doctor, when you have a family to support, well you pass up opportunities you could snap up.

Th. For instance? *[The patient then elaborates on his frustrated ambition and verbalizes resentment at his wife for exploiting him. This provides a basis for examining his dependency needs and his inability to stand up for his own rights.]*

It is seen in this interview that the actual content of what the patient brings into the session may be merely a reflection of deeper feelings. These may be elicited through careful interviewing.

While the comment made to the patient elicited satisfactory associations, it might not have done so at some other time. Thus, the patient might have responded with an outburst, elaborating on what he already had said in a frantic attempt to justify his feeling. He might have reacted also by commiserating with himself more intensely.

Other statements by the therapist may have been made rather than the one utilized. For example, "A lot of demands are being made on you these days. How do you feel about this?" or "Things do seem to

be different. In what ways are they different?" Actually there is no right or wrong about the comments made, and the therapist must be guided by his or her own feelings as to which are the most important aspects to accent. The more experience one has had in interviewing, and the more skill one develops in doing therapy, the more satisfactory will be the selection.

The choosing of themes is complicated by the fact that the individual's verbalizations deal simultaneously with a number of different psychic levels. Most importantly the patient is concerned with three aspects:

1. Current environmental distortions
2. Manifestations of characterologic strivings and facades
3. Derivatives of unconscious impulses and strivings

Existing environmental difficulties constitute a bulk of the individual's preoccupations. This is natural since the person is influenced by the environment in both positive and negative ways. During therapy the patient may discuss factors in his or her environment that facilitate gratification of needs, that produce satisfactory repression of destructive impulses, and that permit of a reasonably good relationship with others. More likely the patient will be prompted to talk about inadequacies in the environment that provoke inharmonious strivings, inspire conflict, create disturbances in interpersonal relations, and vitiate the satisfaction of basic needs.

The patient's characterologic manifestations will always reveal themselves in accounts of current happenings. Involved in the patient's daily life are the specific ways that he or she relates to people, the distortions that contaminate habitual adjustments. These display themselves in attitudes and behavior tendencies toward authority figures and subordinates as well as personally. Such patterns as dependency, aggression, detachment, perfectionism, masochism, sadism, and compulsive ambition may be interwoven into the fabric of personal adjustment. The patient may be unaware of some of these destructive character traits or of their compulsive nature, assume that they are quite normal, or accept them as an unusual though constitutional part of the self. The patient may verbalize circumstances that have thrown one's character strivings out of adaptive balance.

The third and most repressed level involves the deepest conflicts that have survived the passage of time. These were initiated in the formative experiences of early childhood, and consist chiefly of unresolved fears, guilt feelings, and manifestations of shattered security and undermined self-esteem. Such conflicts reflect stages of development, from early infancy to puberty, in which important traumata occurred. They exhibit themselves in such symbolic ways as incorporative tendencies: fears of starvation, oral injury, anal damage, contamination, hostility, murderous impulses, fears of castration; incestuous desires, and penis envy. Many repressive defenses shield unresolved infantile impulses and additionally contribute to the crippling of personality maturity. Because of repression, only distorted and highly symbolized derivatives of unconscious conflicts are available to awareness. These are sufficiently disguised to evade repressive barriers.

The following account of a session illustrates the simultaneous operation of the three main psychic levels described above.

> A patient started the session by reciting an incident that had happened two days previously during which he had experienced a brief attack of anxiety. While listening to a friend talk about golf, the patient began to feel uncomfortable and tense. He was filled with a sense of helplessness and with an expectation of impending but indefinable disaster. The attack passed, but he was left shaken. He could not understand why he had had such an attack, since there was nothing to account for it. As the patient continued talking, he revealed having been perturbed at receiving a letter from his employer in Boston inviting him to a house party at the employer's home to be given in a fortnight. His employer, a tycoon whom he admired, seemed to have an overwhelming amount of confidence in him, constantly commending him as the best man in the firm. He even had hinted at making the patient a director of his organization. Flattered, the patient developed misgivings at having duped his employer into thinking he was better than he was. While conceding that he had done a good job, he was aware of how frightened he was inside, how inferior and weak he felt most of the time—characteristics that contradicted the strength and masculinity his employer had assigned to him. The patient sought to avoid too intimate contact with his employer, lest the latter discover his weaknesses. On a business basis he was able to assume a sufficiently detached attitude to maintain what he considered to be a facade. His self-confident pose, however, was severely challenged whenever he socialized with his employer. Particularly upsetting were contacts with the employer's friends. He felt vastly inferior in their company, especially when they paraded before him their wealth and other material signs of success. The last social visit that he had paid to his employer had been like a nightmare. During the party, attended by important men in the business field, he had felt dizzy and upset. By sheer will power he had forced himself to stay. The next morning he had concocted a false emergency at home, and with vociferous regrets, had cut his visit short. He resolved never to return if he could possible help it.
>
> When the patient was asked, in the session, to talk about his employer, it was apparent that he both admired and envied the latter's great success and forcefulness but resented his employer's curt, abrupt manner. He never had dared challenge the authority of his employer, since this would not have been discreet. Moreover, he had no desire to vent his resentment, since, in his opinion, his employer was a great man who had climbed to the top of his profession with little or no help. In his employer's presence he experienced a feeling like that of a small boy who was on his "good" behavior. That his employer reminded him of his father had become more and

more apparent to him since he had started therapy. His feelings toward his father paralleled those toward his employer in an astonishing way. He had loved, admired, and respected his father; he had feared and resented him too.

Questioned regarding his last bout of anxiety, the patient related having received a surprising invitation from his employer to spend several weeks in the country. As an inducement, the employer promised to take the patient golfing daily. No novice at golf, the patient played a game far inferior to that of his employer. He realized now that he had tried to put out of his mind the invitation of his employer in the ardent hope that something would eventually come up to prevent him from making the trip. He could see that the mention of golf, at the time immediately preceding his anxiety attack, had reminded him then of the visit from which there seemed no escape.

The patient then recalled a dream that he had had the evening of his attack. He was in a large barnlike structure that resembled the house of his grandfather. A large man walked into the room balancing an egg on a bloody stick. Then he saw himself drowning in a body of water. He awoke with a feeling of strangulation. Associating to the dream, the patient recalled the talks that his father had with him during childhood on the subject of sex. His parent had warned of the dangers of masturbation and of sex play before marriage. He recollected how he had, in spite of these warnings, experimented with masturbation and with sex play, constantly anticipating an indefinable punishment. Even as an adult, sex had seemed wrong.

Reviewing the content of this material one may detect (1) an assortment of provocative environmental circumstances (invitation to the home of the employer and the golf incident), (2) characterologic distortions (attitudes toward authority in general and toward his employer in particular), and (3) deep inner conflicts historically rooted in the past (fear of punishment for sexual desires).

The selection of the material to be discussed will depend on what we are trying to achieve in the interview. Because flexibility is the keynote, the focus of concern may have to shift from one level to another—as from problems residual in unconscious conflict to those of an immediate situational nature. We may have to deal with certain levels to the exclusion of others. Thus, in some patients, or in doing supportive therapy, it may be necessary to avoid stirring up inner conflict by keeping the interview on everyday situational problems. In other patients we may purposefully avoid reality discussions, maintaining silences and encouraging the exploration of deeper emotional problems. The kind of content selected must at all times be that which would be most helpful to our immediate therapeutic objective.

In working with unconscious content the therapist must function as a decoder who unravels the symbolic messages from the unconscious. To act in this capacity special training in the language of the

unconscious will be necessary. Interpretation of this language varies in the different schools, as does the emphasis on what is considered the basic core of the neurosis. Thus, a therapist trained in Freudian theory will focus on manifestations of the Oedipus complex; in Kleinian theory, on infantile aggression, envy, and projective identification; in Sullivanian theory, on the devalued self-image and paradoxic distortions; in Adlerian theory, on inferiority compensations as they affect the life style; in Rankian theory, on separation anxiety; and in Jungian theory, on residues of archetypes as they invade and distort the present existence. The patient will soon learn to communicate in the therapist's dialect and to utilize the latter's concepts and formulations in dealing with fundamental aspects of one's experience; however, the therapist will have to spend time educating the patient to think in these terms.

"Reading between the Lines"

There are many times that patients will say with conviction things that they do not entirely believe. Early defenses to avoid hurt and censure continue to operate in adult life toward masking true meanings. This unconscious duplicity is reinforced in the here-and-now by many aspects of contemporary society that endorse deceit in social communication. We become so concerned with the consequences of our behavior (e.g., the effect of what we say on persons whose esteem we seek to sustain) that we exploit counterfeit tactics to please rather than to voice our genuine convictions. While such unauthenticity sometimes has certain immediate practical advantages, we pay a penalty for this indulgence in the currency of fear, hopelessness, guilt feelings, and a diffuse sense of outrage. The shaping of our behavior according to such a spurious design often causes us to live a good deal of the time outside of ourselves.

Taking at face value everything the patient says adds to the patient's hopelessness. Secretly the patients may wish that therapists will see through their verbal camouflage and will then help them endure the consequences. It is toward this effort that "reading between the lines" becomes so vital a tactic in interviewing. I remember one patient, a refined, driving, intellectual individual who spent a good portion of the second interview with me talking about the wonderful woman whom he had married. She was kind, charitable, meticulous, interesting, artistic, in addition to having numerous other virtues including sound judgment and keen perception. I smilingly nodded and said, "Then she must be kind of tough to live with." The patient was startled for a moment, then broke out into gales of laughter. As he

wiped the tears from his eyes, he commented, “I find myself constantly trying to please her, to live up to her standards.” Our focus in interviewing then centered on why he felt he had to be a “good boy” and why he could not allow himself the indulgence of making mistakes. It was to be expected that my seeing through the facade that he had erected would release a good deal of anger at authority in general and his wife in particular.

By a simple maneuver of challenging *in a soft or humorous way* statements that seem out of place or exaggerated, patients may sometimes rapidly be forced to face up to their self-deception. Moreover, they will usually regard the therapist as a trusted ally who can help them stand up to the truth. Unless a therapist can enter the inner world of the patient, empathizing with the patient’s needs and struggles, the therapist will be handicapped in rendering truly significant help.

Guiding the Theme into a Goal-directed Channel

While the dominant theme may be the vehicle of the interview, it is essential to direct the theme toward a fruitful goal. Of their own accord patients may not be interested in moving toward this goal. They may even resist violently attempts to shift the topic of discussion away from the goal that is dominant in their mind. It will be necessary, therefore, to accept the patient’s choice of topic and then try, in as subtle a way as possible, to influence the content of thought toward an important objective.

We may illustrate this, perhaps, by the example of a mule who is hopefully surveying a barn loaded with oats that is in a direction other than that toward which the driver of the mule is taking him. This clash of motives results in an obstinate stalemate, the mule refusing to heed the injunctions of the driver. However, once allowed his freedom, the mule will start for the barn, and it may then be possible to take advantage of his momentum to steer him into a different direction. Our patients often act very much like mules when we try to push them toward an area of discussion in which they are not interested. Instead, if they are allowed full liberty of verbalization, it may be possible to swing them, by careful focusing, toward goals that we consider of vital importance. This is done by establishing a relationship between the subject of the patient’s preoccupations and the area the therapist considers to be important.

For instance, a patient who has recently started therapy comes to a session perturbed at the

indifference of her husband. She has wanted a coat for some months and, after dropping several subtle unrewarded hints, has made an open demand. A vague promise has resulted in no action. Moreover, her husband has been acting bored with family life and has taken advantage of every opportunity to remain away from home, giving such reasons as union meetings and American Legion “get-togethers.” The evening before the present session she felt emotionally excited and wanted to make love, but her husband informed her he was fatigued. He then retired early, and she felt frustrated.

At the previous therapeutic session the patient had professed curiosity about how mere talking could help her complaints of backaches and migraine. She seemed to show some suspicion of the therapist. Since her distrust would interfere with a working relationship, we would be tempted to continue exploring it during the present session. To do this, however, would mean cutting her off from her desire to talk about her trouble with her husband.

Following the principles outlined above, she is encouraged to verbalize her feelings about her husband and an attempt is made to communicate empathy. At the same time her thinking is directed toward her feelings about the therapist. An excerpt of the interview follows:

Th. Was your husband always as indifferent as he seems to be now?

Pt. No, at the beginning of our marriage things were different, more exciting I mean. But it didn’t last more than a short time.

Th. Mm hmm.

Pt. He found more interest in other things than he did me. *(pause)*

Th. What about your relationships with other men besides your husband? Have you ever noticed how they react to you? *[The attempt here is to delineate a larger problem with men into which the pattern of her relationship with her husband fits.]*

Pt. (pause) Well, I never thought of it. I never got along too well, that is got too close. That is before my husband, I mean.

Th. What about *our* relationship? How do you feel *we* are getting along? *[Here an attempt is made to focus on the therapeutic relationship.]*

Pt. (flustered) Why I just didn’t, don’t know. I keep wondering if this is what will help me.

Th. Whether it’s the sort of thing that will make you well?

Pt. Yes, I just don't know what you expect me to do.

Th. What do you think I expect you to do?

Pt. That's it, I just don't know if I will do what is right, that you will think I'm doing well.

Th. I see. I wonder if you don't have ideas about how I must feel about you.

Pt. Why, *should* I?

Th. It would be rather strange if you didn't have *some* ideas about me and perhaps have wondered about how I feel about you.

Pt. Yes, as a matter of fact, I did wonder. But why should you feel anything about me?

Th. Perhaps you feel I am indifferent to you?

Pt. Why should you feel any other way?

Th. In what way have I acted indifferently? *[From this point on there is an exploration of her expectations of rejection in the therapeutic relationship.]*

Were the patient in the middle phases of therapy, and were the relationship with the therapist a good one, the focus of therapy would be on exploring the broader dynamics of her feelings that men reject her, on the role that she plays in bringing on rejection, and on the genetic origins of this trend. The interview would be directed into channels that would point toward these areas.

The goals pursued are also related to the kinds of therapy done. In supportive therapy the ultimate goal may be the correction of a situational disturbance. The therapist here organizes the interviewing around the following aims:

1. The establishing of a working relationship with the patient.

2. The understanding of all factors in the environment that provoke stress.

3. The evolution of a plan for coping with the stress situation and the execution of this plan once the individual is brought to a realization of his or her potentialities and aptitudes.

4. The termination of therapy.

In reeducative therapy the general goal is a reorganization of the individual's destructive attitudes

and behavior patterns. Interviewing is pursued along these lines:

1. The establishing of a working relationship with the patient.

2. The understanding of the more conscious irrational attitudes and patterns that interfere with a good adjustment.

3. After evaluating positive assets and liabilities, the mobilization of activity toward a reintegration of attitudes with reinforcement of positive factors and unreinforcement or extinction of behavioral deficits.

4. The termination of therapy.

In reconstructive psychotherapy the successive goals are these:

1. The establishing of a working relationship with the patient.

2. The understanding of unconscious conflicts through exploration of verbal associations, dreams, fantasies, slips of speech, and behavioral irrationalities, both inside and outside of therapy.

3. The utilization of the gained insight toward the freeing of oneself from the effects of unconscious conflict, with resolution of blocks in self-development and maturity.

4. The termination of therapy.

All activity during a session, including the selection of content for focusing, is organized around the goals that dominate an existing phase of therapy.

The general area of inquiry around which the interview is focused will, furthermore, vary with the kind of therapy performed. Thus, the prime focus may be on the environmental distortions that surround the person and on the symptomatic disturbances that immobilize him or her. This is the case in supportive therapy where the aims are, first, to reduce environmental pressures to a point where the patient can deal with them with his or her existing personality resources and, second, to restore homeostasis within the person that was unbalanced by illness. No concentrated attempt is made here to modify character strivings or to deal with deep inner conflicts except where they act as immovable resistances to rectifying the existing situational or symptomatic disturbance. The focus in reeducative

therapy may involve examining how the individual relates to people and the contradictions of one's disturbed drives. An inquiry into the more conscious character drives may have to be made, with the hopes of enabling the patient to suppress those drives that disorganize adjustment and of encouraging others that expedite adjustment. A search for the more unconscious drives is the object of reconstructive therapy. Here the understanding of the more repressed strivings is facilitated by the examination and analysis of dreams, fantasies, and transference manifestations. There may be an exploration of infantile and childhood experiences and fears as well as the immature strivings they embrace.

Circumscribing the Area of Subject Coverage

Studies of the learning process show that only a relatively limited number of things can be mentally absorbed and integrated at the same time. For this reason, once a dominant theme has been guided into a goal-directed channel, it is essential to focus on as concentrated an area as possible during any one session. Taking up one subject at a time and exploring as many facets of it as possible will result in the most effective use of the interview.

A patient, in the middle phases of reconstructive therapy, for example, presents in one session the dominant theme of how, since her marriage, she has tended to give up her own creative activities for family responsibilities. The exploration of her attitudes toward married life, and the sacrifices entailed therein, are believed by the therapist to be in line with the goal of understanding the dynamics of her psychosomatic complaints. By verbal and nonverbal means the therapist, therefore, encourages the flow of verbalizations along these lines. The patient responds by recounting the events of the past day. Her child dawdled at breakfast. This irritated her so much that she felt like pushing his face into the cereal. Things at home have continued to be "in a mess." Her part-time maid is on a rampage and may have to be discharged. She fears getting another maid with problems as serious or more serious than those of her present maid. Because her maid had come to work late yesterday, she was delayed in attending a meeting of the parent-teacher association. She anticipates getting out of the house, but she does not derive too much pleasure from parent-teacher meetings. Indeed, she has been having some difficulty with an aggressive, argumentative member of one of the important committees who is opposing a resolution for a new school building. She is considering giving up her post as secretary of the organization in order to spend her time studying Spanish. Some day she would like to visit South

America because she has been told it is a romantic country. This reminds her of a book she has been reading about Brazil. The book is about the Amazon River. It was sent to her by the Book-of-the-Month Club. She wonders if she would really be happy in South America because of all the insects and diseases that must infest this continent. The United States is the healthiest of all places to live. If only she could be happier. She had hoped that therapy would be able to do this for her. Perhaps she should explore the possibilities of getting an outside part-time job. She might in this way make herself more useful.

This type of rambling achieves very little unless we can confine it to a limited, but significant area. Possibilities are:

1. Exploration of her feelings about her child and his dawdling. A question such as "Your child, does he dawdle much at meals?" may open up the subject of her attitudes toward her child and his rebellious behavior. This may lead us into the field of her relationships to other members of the family and her feelings about herself as a wife and mother.

2. Exploration of her activities away from home, for instance, the teacher-parent association and the possibilities of her getting an outside job. We may ask, "You put in a good deal of work there. What do you get out of it?" This may encourage an elaboration of her ambitions.

3. Exploration of her feelings about the recalcitrant member of the association. The comment, "This woman must stir things up in you," may help her verbalize her feelings of competitiveness and her attitudes toward this woman as well as toward the other members.

4. Exploration of the general subject that things are not entirely satisfactory at home. One may remark, "There are things that go on in your life right now that bother you. What bothers you most right now?" This may center the patient's attention around her current unhappiness.

5. Exploration of her feelings about therapy. A comment may thus be phrased, "You seem to be disappointed that therapy has not done for you what you had anticipated it would do for you." This would open up an inquiry into her resistances to therapy and the therapist.

Which of the above aspects to stress would be difficult to say, for this would be determined by the needs of the immediate situation. However, there are certain general rules of priority in content

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selection. Sensitizing oneself to the trends in the patient's verbalizations, one may select topics in the following order:

1. Negative feelings toward the therapist.

2. Negative feelings toward therapy.

3. Unwarranted or unrealistic attitudes toward the therapist, such as distrust, sexual demands or fantasies, aggressive impulses, overwhelming dependency, and serious detachment.

4. Resistances to exploring attitudes or feelings that could give the patient insight into the problem.

5. Resistances to translating insight into action where the patient has gained an understanding of the problem.

6. Feelings of any sort that are verbalized.

7. Feelings that are not openly expressed but seem to underlie the content of thought.

8. Dreams, fantasies, and slips of speech (except in supportive therapy).

9. Observations of the relationship of symptoms to certain environmental happenings.

10. Pressing environmental concerns and interpersonal relationships with attempts to differentiate realistic problems from projections.

11. Important past experiences and relationships.

Returning to our patient, it will be seen that on the basis of priority items, the second possibility listed (negative feelings toward therapy) would be the best. The interview would be focused as much as possible on her feelings about therapy and why she seems to be discouraged at her progress. This does not imply that the other possibilities are unimportant. However, in order for the patient to benefit most from the interview, dealing with her resistances to therapy would be strategically more important than exploring a character trait at a time when she is in an emotionally discouraged mood. Later the other possibilities might be considered appropriate items for discussion.

In order to help circumscribe the areas explored, the therapist may apply the principles already

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outlined for maintenance of the flow of verbalizations, that is, as long as the patient is talking about a selected trend. If the patient veers off into an irrelevant area, the therapist may focus on pertinent material by quickly summarizing what the patient has said and then asking a question related to the selected area. Resistance to exploring this area, in the form of blocking, evasions, fatigue, and other reactions, will have to be dealt with by further questions or by interpretations. If the patient persists in dealing with an unimportant subject as a defensive manifestation against handling important material—for instance, if one insists on talking about one's car or a current television program at a time when important relationships with people should be explored—the therapist may employ certain discouraging tactics. Thus, an attempt may be made to divert the patient with certain comments, such as "Now that's very interesting, but I'd like to get back to what we were just talking about." A question dealing with this material may then be asked. If the patient again resists, the therapist may have to handle the patient's resistance directly.

A patient who had been discussing his feelings of discouragement because of his impotence mentioned an impending date with a young woman who was a musician. He then veered off into a prolonged account of the virtues of Dixieland jazz over Bebop. A fragment of the recorded interview follows:

Th. That's very interesting, but I'd like to go back to this young woman and the date with her. How do you feel about it?

Pt. (pause) Well, all right, she's a very interesting sort and we have a lot in common. I expect that she doesn't approve too much of my views about music because she has some ideas of her own. She likes jazz all right, but not the way I do. Now we happened to be together at Eddie Condon's place one night, and his orchestra played a whole series of old numbers, reorchestrated for his band. He …

Th. (interrupting) Yes, there may be a number of differences of opinion that you have with this girl, but what do you expect will happen when you have your next date with her? *[bringing patient back to the subject]*

Pt. Well, I don't know exactly. I suppose we'll end up in bed.

Th. How do you feel about that?

Pt. I don't know. It sort of scares me in a way. If I could only have an erection and get started.

Th. Perhaps what concerns you is that you may have a repeat failure on your record, that is, that you won't be able to perform. That must upset you.

Pt. It sure does, I hardly feel like talking about it. In fact I wanted to call the whole thing off.

Th. Maybe that's why you find it so hard to talk on this subject. It upsets you.

Pt. Yes, yes, it does, and then I feel like chucking the whole thing up. *[The remainder of the session is concerned with dealing with the patient's resistances to exploring his impotency problem.]*

INCULCATING INSIGHT

It is important to realize that insight is not always essential. Behavioral changes can come about purely as a consequence of conditioning and reinforcement. Interestingly, insight regarding what has been responsible for faulty coping patterns may follow such behavioral change. On the other hand, we always strive for some cognitive improvement or change, and often the therapeutic focus is on bringing the individual to an insightful awareness of what is behind his or her difficulties. This awareness (insight) then can act as a motivating force to inspire the person to take steps to change offensive patterns. Peculiarly, the "insight" may not always be valid. The patient may arrive at false conclusions through his or her own resources, or by incorporating incorrect assumptions offered by a therapist dedicated to an anomalous psychological system. Sometimes spurious insights, alleviating tension and bringing about freedom from fear, may enable the person to give up pathological defenses. The individual is then free to pursue behaviors which are constructive and which through reinforcement may lead to a healthy adaptation. On the other hand, if the false insight is a blatantly deceptive canard, the individual will eventually see through it, and he or she may experience a relapse.

In the cognitive and reconstructive therapies an important objective is the deliberate inculcation of insight. The act of verbalization often enables the individual to convert vague feelings and undeveloped convictions into concrete explicit formulations. The therapist helps catalyze the process by getting the patient to focus on significant areas of his or her life. Before this can be done, however, the therapist must know which aspects are important enough to stress at any given time.

By observing the patients' verbal and nonverbal behavior within the session, by listening to their account of what has happened in their relations with people outside of therapy, by scrutinizing their dreams and fantasies, the therapist will gain an understanding of driving motivational forces. Everything patients say or do during the treatment session must be carefully noted. This includes how they walk into the room; their posture as they sit in the chair, their bodily movements, gestures, and facial expressions; random muscle spasms and tensions; how they get out of the chair; and how they leave the

room. In the patient's verbal behavior the therapist must note not only the content of what is said, but also the inflections, intonations, evasions, silences, blocks, and other evidences of emotion. Listening intently to *what* the patient says, the therapist concentrates on *why* certain verbalizations occur—the underlying feelings and conflicts that evade the awareness of the patient. The therapist must become alerted to the meaning behind the content by observing the patient's associational processes, shifts in emphasis, omissions, denials, inconsistencies, undue underscorings, inappropriate attitudes or emotions, and slips of speech. The therapist must be constantly sensitive to the existence of trends in the content of thought and to underlying emotions. The more experience one has had, the more "intuitive" one will be in perceiving significant areas.

At the therapist's disposal are a number of maneuvers to use that help the patient achieve insight. Among these are accenting, summarizing, restating, reflecting, establishing connections, maintaining tension, extending support, and making interpretations.

Accenting

Where an important trend in the patient's verbalizations is observed, the therapist may ask a number of questions related to this trend or repeat again and again what the patient has said. By bringing it to the patient's attention constantly, forcing thinking about it in a concentrated way, the trend is highlighted in the awareness of the patient. This encourages the patient to explore its purpose and origin. Accenting is also useful in getting patients to accept certain facts about themselves and their situation. These may have escaped verbalization for the following reasons: (1) a lack of incentive to reveal facts, (2) a conscious fear of such revelations, (3) unconscious fear of the factual implications, (4) a confusion as to which facts are important, and (5) complete ignorance of what the facts are, due to repression. Pointed questions help their patients break through resistances. Repetition serves the added purposes of questioning the validity of the patient's comments and of obtaining more information about specific topics.

Summarizing

Patients often ramble in their verbal accounts. They may become so engrossed in details that they

lose sight of the interrelationship of the various topics discussed. They may fail to connect casual happenings with basic themes. A rapid summarization from time to time, therefore, is helpful in pulling together material that seems to be uncoordinated. It is useful also as a measure preliminary to a pertinent question intended for purposes of focusing.

Restating

Recasting certain statements of the patient into different words brings out related aspects of the material that may have escaped attention. It also explicates what may be difficult for the patient to verbalize. Repetitive reformulations emphasize important trends in the patient's mind and help to rephrase his or her problems in more cogent terms.

Reflecting

Reading between the lines of what the patient says, the therapist becomes attuned to feelings affiliated with verbalizations and to emotional undercurrents of the content of thought, as well as to attitudes that have not been expressed. The therapist reflects these back to the patient, putting them into terms that the patient will be able to accept without stirring up too much anxiety. For instance, a patient launches into great praise of her employer and the possessions of the employer: Cadillac car, country estate, and important friends. The therapist senses jealousy and restrained contempt in the patient's tone and reflects these feelings by saying, "Yet some of the things your employer does may irritate you." The patient responds by cautiously criticizing, then openly attacking her employer. The exposure of the patient's feelings and acceptance of these by the therapist relieve guilt and encourage a deeper exploration of emotions and conflicts.

Establishing Connections

Due to the factor of repression even obvious connections between symptoms, feelings, and inner conflicts may not be seen by the patient. The relationship of daily happenings in the patient's life with tension and anxiety states that are constantly being mobilized also continues to remain vague. The patient will, therefore, require help from the therapist who establishes the associations for him or her. A

woman suffering from bouts of migraine, for instance, manifests such attacks following contact with strong, aggressive females. Confoundingly, the patient has no idea that there is any association between her attitudes toward aggressive women and her headaches. In recounting her experiences she presents these two situations as isolated and unrelated events. Whenever this happens, the therapist attempts to fuse the two by saying, "Now here is a situation where you get in a tangle with an aggressive woman and following this you get a headache." The patient may not respond with insight to this consociation at first, but repeated comments along the same line, whenever the facts justify them, bring the patient around to seeing a casual relationship of one to the other.

Maintaining Tension in the Interview

The maintenance of a certain amount of tension in the interview is essential in getting patients to think things through for themselves. Tension acts as a driving force by creating in the patient an incentive for change through active participation in the therapeutic process. On the other hand, a relaxed, tensionless state tends to diminish activity. Tension may be created in a number of ways, particularly by focusing on provocative topics, by asking challenging questions related to painful or avoided subjects, by giving patients interpretations of their disturbed attitudes or behavior, and by the strategic use of silence.

By maintaining silence the therapist initiates a state of discomfort in the patient. Discomfort deepens into tension that may promote a spontaneous exploration of feeling. Unfortunately, the patient may react adversely to silence, interpreting it as evidence of the therapist's rejection or hostility. For this reason silence, in therapies other than classical psychoanalysis, must be employed discreetly and not too frequently, the other indicated measures being more often utilized to promote tension.

Where tension is created in the interview, it must never be permitted to grow to a point where it overwhelms the coping resources of the individual, producing destructive or infantile reactions, such as acting-out tendencies and other strong resistances to the therapeutic process. In the event such contingencies occur, the therapist will have to step in with supportive measures to alleviate the tension state.

Extending Measured Support

Measured support is given the patient whenever the ego resources crumble and the patient shows symptoms of collapse. This temporary prop may help the patient retain the insights he or she has developed, since it prevents the ego from employing repressive and regressive defenses elaborated to preserve its integrity. An ego threatened by too great anxiety may protect itself by repudiating the insights it should integrate. Among the measures practiced to give the patient support are reassurance, avoidance of conflictual topics, and direct advice and guidance. Reassuring comments, for example, may involve statements such as, "In spite of all your difficulties, you have achieved a good deal in life." Following this, one may enumerate positive achievements of the patient or the patient may be told, "All people make mistakes and go through periods of misery." Such techniques must be employed sparingly and only where absolutely necessary, in reconstructive therapy.

Confrontation

Patients may be confronted with certain contradictions in their behavior, queries being made as to why they react the way they do. This will impose pressure on them, to which they will respond variantly: defensively with rationalizations, angrily with rage, indifferently with detachment, tremulously with anxiety, or with a host of other responses fashioned by their feelings toward the therapist, how they imagine the therapist regards them and their foibles, and what the exposure does to their self-image. The way confrontations are communicated—the wording, tone, and facial expression of the therapist—will influence the quality and intensity of the patient's responses. Some highly challenging confrontations may be made, and they will be accepted if presented in a kindly, non-condemning, firm, but understanding manner that conveys a nonjudgmental and non-punitive intent. On the other hand, confrontations posed accusingly or demeaningly, or before a good working relationship has been established, may be resisted violently.

Making Interpretations

The making of interpretations, especially in reconstructive therapy, is an important step in promoting insight since it constitutes a frontal attack on existing blocks in patients and enables them to

come to grips with anxiety. Anxiety is at the root of practically all psychopathologic problems. Defenses against anxiety cripple the adjustment capacities of the person, causing one to react in an inappropriate way to casual happenings. Interpretations directed at bringing patients to an awareness of their anxiety show them how they are responding to this emotion and the defenses that they utilize in warding it off. Interpretations also help to dissolve resistances that constantly interfere with patients' capacities to think for themselves. Interpreting blocks that prevent patients from becoming aware of their problems is a prime task in interviewing.

While interpretation is one of the chief tools of the psychotherapist, it is not without its dangers. Confronting the patient with repudiated aspects of his or her psyche may promote greater anxiety and stimulate more obdurate resistances toward the warded-off content. Consequently, it is important to interpret to patients only material of which they have at least preconscious awareness. For instance, a patient came late for a session. By observing his behavior and verbalizations, the writer got the impression that the patient felt hostile toward him. This seemed to be substantiated by a dream in which the patient fled from a monster who turned into a doctor. There was a temptation to confront the patient with his hostility. Therapeutic conservatism however, necessitated biding one's time until the patient came out with a statement of how he felt. The following is a recorded fragment of the interview:

Th. I wonder how you have been feeling?

Pt. All right, I guess, *{pause*)

Th. All right? *(pause)*

Pt. Well, yes and no. I felt a little upset when I found I was late.

Th. Mm hmm.

Pt. I just can't seem to remember the exact time of my appointment.

Th. I wonder why? [*focusing on the causes of the patient's lateness]*

Pt. I guess so many things are going on that I just don't think of it. *{pause)*

Th. I wonder if there might be other reasons? *[again focusing on causes]*

Pt. Are there, I mean do you think there are?

Th. I don't know, but often when a person comes late, he does so because of certain feelings about therapy or the therapist, *(long pause)*

Pt. Well, to tell you the truth coming here does upset me, that is, lately.

Th. I wonder why?

Pt. I keep getting feelings as if you've done something, or haven't done something, like as if you want to spite me.

Th. Mm hmm.

Pt. Yes, that's what it is. You know this is silly because I can't figure out why I feel this way.

Th. Is there anything I have done that has upset you? *[attempting to differentiate reality from projection]*

Pt. Honestly, doctor, you haven't.

Th. Then you must be resentful toward me for some other reason.

Pt. I feel flashes of resentment, but I don't know why. That's probably why I've had trouble coming here, on time I mean.

It will seem from the above that the patient has been led to make his own interpretations. Dangers are minimal where this is done. The therapist helps the patient by giving cues, by arranging material in a sequence, and by asking pointed questions. The patient is then in a position to figure things out for him or herself, which will facilitate therapeutic progress immeasurably.

From time to time, however, it will be necessary to give the patient direct interpretations, especially when resistances prevents making them on his own. The kind of relationship that the therapist has with the patient and the manner in which explanations are presented are important here. If the relationship is a good one and if disclosures are made in a nonjudgmental way, they can have a beneficial effect. Interpretations must always be given in such a manner that the patients feel free to reject them if they wish. To insist that the patient accept proclamations is a poor tactic.

Instead of presenting an interpretation as an authoritative dictum, one may precede it with such phrases as "perhaps" or "it would seem as if." This gives the patient a feeling that the therapist is not being arbitrary. Where there is good reason for feeling an interpretation to be true and where it has been offered to the patient and roundly rejected, the therapist may say, "Well, maybe it doesn't appear plausible right now. Suppose you think about it, and observe yourself, and see if later it makes more

sense." If the patient tries to force the therapist into being absolute in his or her declaration, the therapist may reply, "I get the *impression* that the situation as I have indicated it *may* be true. But it's important for *you* to test it out for yourself and see if you feel it really applies to you." Eventually the patient may come around to accepting the validity of the therapist's impression.

Interpretations may be made in relation to any unconscious or partly conscious aspect of behavior. Of particular importance is its use in dealing with resistance and in uncovering repressed material. Interpretation of resistance often helps the patient make progress in therapy. A patient with the problem of impotence, for instance, comes into a session in a distraught state. He rambles along on inconsequential topics and keeps looking at his watch every few minutes as if he is anxious for the session to end. The recorded fragment follows:

Th. I wonder why you have been checking the time so often, *[bringing the patient to an awareness of an unusual aspect of behavior]*

Pt. Oh, I've been wondering what time it is.

Th. I see. (gazing at his own watch) It's 10:24 (pause)

Pt. Time seems to go so slow today.

Th. I wonder why?

Pt. I just don't seem to have anything to talk about.

Th. Nothing?

Pt. I can't think of anything.

Th. I wonder if there is anything that bothers you, that you don't like to talk about? [focusing on possible resistance]

Pt. Like what?

Th. Well, what would be unpleasant to talk about? (pause)

Pt. (smiles) You know what flashed through my mind?

Th. What?

Pt. I almost forgot the date I made with Helen tonight.

Th. Mm hmm.

Pt. It's something I feel I've got to do, but I don't feel up to it. Maybe I'll call it off.

Th. Any reason for calling it off?

Pt. It's nothing too important, I thought I might go to the opera tonight.

Th. I wonder if you just don't want to avoid seeing Helen because of the fear of the sex business. [interpreting]

Pt. I suppose I should go through with it, but I'm afraid of disappointing her again.

Th. Mm hmm. And suppose she was disappointed?

Pt. I'd be disappointed and upset.

Th. You feel you want to be successful and don't want to face any disappointments, [further interpretation]

Pt. (laughs) I guess that's why I didn't want to talk, to tell you I was going to break the date. I guess I shouldn't really break the date because it's silly to feel I'll be rejected. I must be really scared of failure.

Interpretation of the content of the repressed is less frequently practiced and is utilized only in reconstructive therapy where the therapist has a very good relationship with the patient. A woman dating a man for the first time experienced faintness, heart palpitations, and overwhelming fear in his presence. She talks of this experience during the session. The recorded fragment follows:

Th. What do you think this is all about?

Pt. I don't know.

Th. Here you meet this man, and then you get this attack.

Pt. Yes, it sounds funny.

Th. Do you think there is any connection between seeing this man and your attack?

Pt. There must be, but what?

Th. Well, what? *(pause)* What do *you* think?

Pt. I … I don't know, doctor, I really don't.

Th. Well, perhaps the man stirred up feelings in you, upset you, scared you? [*interpreting deep fear of men]*

Pt. (blushes, stammers, pauses) Yes, I feel upset. This kind of man makes me feel funny.

Th. What kind of man is he?

Pt. Well, his eyes and build. He reminds me of my father when he was drinking, which was most of the time.

It is important to remember in interpreting the content that material from dreams, slips of speech, and transference manifestations should not be directly interpreted until the patient gives evidence of having some conscious or preconscious awareness of the material. The tone of voice, the pauses, and the emphasis are as important as the content of the therapist's interpretations. Creation of word pictures can convey meanings more readily than abstract intellectual statements. Hendrick (1958) contends that the therapist functions best in interpretation not by paraphrasing what the patient reported but by indicating at appropriate moments what the patient was not reporting.

Too broad interpretations, covering the wide range of the patient's reactions, are not as effective as specific, pointed, limited interpretations directed at a target area. Patients are better able to generalize from these concentrated thrusts into their defensive structure, particularly if they are repeated whenever they indulge themselves in neurotic activities that have for them aversive consequence.

Interpretations must be made repeatedly to be effective. The first interpretation may be resisted violently. If the patient has an untoward reaction, the therapist must respect the patient's resistance, and perhaps make allowance for the fact that the interpretation may be wrong. The therapist may say, "Perhaps we can explore this resistance further to see what the real situation may be." As the core of the resistance is resolved, patients may themselves later acknowledge the accuracy of the therapists' observation, or present it as their own discovery.

Interpretation is so vital a technique in interviewing that a special chapter is devoted to it in a later section of the book (see Chapter 45).

TERMINATING THE INTERVIEW

The proper termination of the interview is extremely important. There are some therapists who mismanage this phase of the interview due to a fear that they may offend the patient. Thus they are unable to interrupt a patient at the end of a session for many minutes after the interview time has terminated. The invasion of the next patient's hour complicates the schedule of the therapist and often creates resentment in the succeeding patients.

No matter how lenient the therapist may be in other respects, strict adherence to a time schedule is important. If at least 5 minutes' interval between patients is allowed, the therapist will be able to extend several minutes' time to a patient who is upset or to one who is dealing with highly charged material. The only exceptions to a rigid time schedule are treatment sessions with very sick patients. Here, at least 15 minutes of leeway between sessions should be arranged in advance to allow for an extension of the interview if necessary.

In terminating a session, one may take the opportunity in a pause in the patient's conversation to say, "all right" (mentioning the patient's name) or "all right, we meet again on______" (mentioning the next appointment date). This interruption becomes a signal to which the patient will respond automatically after it has been used several times. In the event the patient is discoursing on an important topic, the therapist may add, "We'll continue with this next time." If the patient, on occasion, continues to talk for too long after interruption, the therapist may simply say, "I'm afraid we'll have to stop. We'll talk about that next session." By his or her manner, the therapist should convey an interest right to the moment that the patient leaves the room. It is important not to dismiss the patient arbitrarily nor to engage in other tasks, like reading one's mail, before the patient goes.

Some patients linger at the door talking on and on. The therapist here may remark, "That's very interesting. Suppose you think about it, and we'll discuss it next time." If the patient asks a question that requires time to answer, the therapist may say, "That's a good question. Suppose you think about it, and we'll talk it over next time you come."

SPECIAL PROBLEMS IN INTERVIEWING

Occasions will arise when patients will bring up names and events that they have mentioned in the past that the therapist does not remember. Here the therapist may remark, "I don't distinctly remember. I wonder if you would mind repeating what you had said about (mentioning the person or the event) to refresh my memory."

If the patient asks the therapist a personal question, it is important to find out why the question is asked. Thus if the patient asks, "Doctor, are you married?" the therapist may reply, "You're curious about

me.” After the patient has responded, the therapist may ask, “Do you think I’m married?” As a general rule, it is best to be truthful with a patient, and, once the reasons behind the patient’s questions are discerned, they should be answered as directly as possible.

If the patient indulges in self-devaluation by making such statements as “I’m a queer, peculiar person,” or “I really am terrible,” or “I’m a hopeless mess,” the therapist must never agree. One may ask, “What makes you think you are?”

If the patient continues to engage in intellectual discussions or talks about topics like the weather, sports, and current events, one may interrupt in a manner illustrated by the following excerpt:

> *Pt.* What do you think about the President and the steel industry? Isn’t it something terrific? When I heard about it, it made me feel we were in for exciting times. The *Times* editorial says …
>
> *Th.* Yes, now what about you? *[The focus may also be brought back to the patient with such questions as “How does that affect you?”]*

There will be times when the therapist feels restless and may manifest discomfort by shifting around in the chair or moving his or her hands and feet. These movements may be interpreted by patients as evidence of the therapist’s disinterest or even maladjustment. If the patient comments on the therapist’s fidgetiness, the therapist may ask the patient what he or she believes this signifies. If an answer is not easily forthcoming, the therapist may ask the patient if he or she believes that the therapist’s movements indicate disinterest. The therapist may, if the facts warrant it, give the patient a plausible explanation for the restlessness, such as that sitting all day in a chair makes one want to stretch one’s muscles a little. This does not indicate disinterest in the patient.

One should resist the urge, tempting as it may be, to “command” the patient to execute certain tasks; to engage in talk about oneself, one’s accomplishments, and one’s problems; or to chastise the patient irrespective of the provocation.

THE INTERPERSONAL CLIMATE OF THE INTERVIEW

Without a congenial working relationship with the patient, there will be little progress even with the most expert interviewing techniques. A proper atmosphere will be present where the therapist

possesses personality qualities of sensitivity, objectivity, flexibility, and empathy; where the therapist accepts the patient uncritically, refraining from arbitrary, moralistic, and punitive responses; and where the therapist shows sincere respect for the patient's growth potentials. The maintenance of a tolerant, accepting, permissive attitude will eventually convince the patient that the therapist's role is to help the patient to understand himself or herself, and not to pass judgment. This unqualified, sympathetic acceptance enables the patient to explore further within the self and the environment, the sources of trouble, helping the individual to bring up material difficult to verbalize even to oneself. The calm scrutiny of his or her productions, with absence of praise, surprise, blame, or shock cuts deeply into the defenses of the patient, helping to expose the most disturbing and painful conflicts.

Were rules for maintaining the proper interpersonal climate during interviewing to be enumerated, the following might be listed:

1. **One should try to put oneself in the patient's position in order to see things from that point of view**. It is obviously impossible to feel exactly what the patient feels because his or her reactions are habitually different from the therapist's reactions. Nevertheless by approximating the patient's situation as closely as possible and considering the latter's background and experience, the therapist may be able to communicate an empathic warmth.

2. **One should appreciate the impossibility of understanding the patient's reaction patterns from the standpoint of common sense**. Realistically viewed, the patient's symptoms and behavior seem futile and destructive. Yet they are compelling and persist in the face of the most intense exercise of will power. It is necessary to realize that the years of conditioning responsible for symptoms will not yield themselves to a few months of therapy.

3. **The therapist ought to recognize that he or she inevitably will be prejudiced in relation to some aspect of the patient's problem**. One cannot escape being disturbed and perhaps even shocked by certain past experiences or by present perverse and antisocial impulses of some patients. The fact that the patient's values conflict with one's sense of "right" and "good" does not necessarily make them "wrong" and "bad." Cognizance of this will encourage greater tolerance of standards and attitudes that do not coincide with those of the therapist.

4. **The reactions of the patient toward the therapist—such as awe, reverence, or hostility—often have little to do with the therapist as a real person**. They may be carryovers of

attitudes toward past authorities, or they may be dramatized feelings toward idealized authorities. It is, consequently, important not to react to unpleasant, seductive, insulting or provocative responses as if they were personal assaults or favors.

5. **The therapist's reactions to the patient may also be determined by projections from the therapist's own past**. It is essential to examine responses toward the patient such as anger, boredom, sexual feeling, and overconcern. Not only must the expression of such responses be controlled, but an attempt should be made to analyze them as to source and meaning. While personal biases and blind spots may be recognized, they may still be hard to control. But recognition of them will be of great help in preventing a too harsh judging of the patient and a blocking of his or her rights to self-determination.

6. **Flexible and tolerant leadership is the ideal matrix of the therapist-patient relationship**. No matter how passive or nondirective the therapist may wish to be, he or she remains the leader in the therapeutic relationship. The manner in which leadership is applied will help determine treatment results. If the leadership is arbitrary, intolerant, and punitive, this will merely repeat the reactions of past traumatizing authorities. The patient may respond with compliance or defiance, and there will be an absence of constructive participation. If the leadership is minimally arbitrary, the patient will have an opportunity to work through feelings toward authority, perhaps gaining a new self-concept in the direction of personality maturity. The therapist accordingly must refrain from dominating the interview and allow the patient to talk freely despite rambling. The therapist must never cross-examine, ridicule, laugh at, or belittle the patient, nor pointedly argue with the patient or engage in extensive polemics. Contraindicated are open disagreements with the patient over religion and politics. The therapist must respect the patient's rights to his or her own ideas and convictions, even though these are senseless or neurotic. There will be times when the tolerance of Job will be required, even while the patient is making what seem to be unnecessary mistakes.

7. **There is a need for faith in the basic goodness of human beings, in the potentialities that all people possess for personality growth and maturity**. The therapist must view disturbed reactions as responses of illness and must respect the essential integrity of the patient in the face of any abnormalities displayed.